Profiles of the Texas Center for Infectious Disease, South Texas Hospital and University of Texas Health Center at Tyler

Governance

Governance of the TDH hospitals is delegated by the Texas Board of Health to the Hospital Oversight Committee for each Hospital. The Board of Health has custody, jurisdiction and control of the maintenance and operation of the hospitals, and has ultimate responsibility for the quality of care provided at the hospitals.

The Commissioner of Health establishes each hospital oversight committee and charges each committee with the responsibility of fulfilling all duties regarding the hospital imposed on the Board by law. The hospital oversight committee at each hospital functions in accordance with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for hospital governance and fulfills the responsibilities of governance, with exception of the non-delegatable power and duty of the Board to adopt rules. The Commissioner also appoints a Hospital Director to jointly administer the two hospitals with the support of an Assistant Director at each location.

Governance of the University of Texas Health Center at Tyler is with the University of Texas System Board of Regents.

Texas Center for Infectious Disease

History

The Texas Center for Infectious Disease (TCID) was opened in 1953 as the San Antonio State Tuberculosis Hospital with a capacity of 408 beds. In 1955 construction of eight additional nursing units was completed bringing the total capacity to 956 beds. By 1956 there were a total of 15 buildings that supported the 956 inpatient beds. Ten buildings were transferred to TDMHMR in 1977 to create the San Antonio State School. This left 150 beds in what was then called the San Antonio State Chest Hospital.

During the 1960's and 1970's, the decline in the number of TB cases and the conversion to outpatient therapy as the standard tuberculosis treatment, contributed to the decline of tuberculosis inpatients at TCID. In addition, Directly Observed Therapy (DOT), which was initiated in 1992, has been important in the success of outpatient therapy. In 1977, as a result of the reduced need for inpatient beds, several buildings were converted to house a pilot program for patients with chronic respiratory disease, a project that is no longer available.

By the 1980's, the general improvement in the standard of living, effective public health measures and the development of the major tuberculosis drugs (Streptomycin, Isoniazid, PZA, and Rifampin), contributed to the further decline in the incidence of tuberculosis in the United States and most of the long term care treatment facilities throughout the country were phased down or closed. In the case of TCID, the majority of the facilities were turned over to the

Department of Mental Health and Mental Retardation for use as a state school for the mentally retarded.

However, in 1986-1987, tuberculosis reversed its trend of decline and began to increase in the United States. Of particular concern was the development of increasing numbers of unrecognized drug resistant forms of tuberculosis. As a result of this increase in TB cases and the concern about controlling the problem, the Texas Legislature in 1993 changed the name of the hospital to the Texas Center for Infectious Disease and authorized 109 inpatient beds to be available to treat patients with TB, Hansen's Disease and other health problems.

At present, TCID has the largest number of beds in one location in the United States to treat patients with tuberculosis and other infectious diseases. TCID also hosts and supports three additional public health activities and outpatient services:

- **Women's Health Laboratory which currently performs approximately 290,000 tests per year, predominantly cytopathology (pap smear) screening;**
- **Research laboratory which conducts sophisticated research in infectious disease;**
- **TB Education Center which offers professional consultation and continuing education to Texas professionals treating TB and other infectious diseases.**

Service Volume - Inpatient

		1997			
		Texas Center for Infectious Disease			
Inpatient					Avg. Daily
		Admissions	ALOS	Pt. Days	Census
TB		175	114.71	20,075	55.00
Medical		8	62.96	504	1.38
HIV/Aids Related		18	223.06	4,015	11.00
	Totals	201	122.36	24,594	67.38

The medical admissions for 1997 were primarily for patients with diabetes mellitus. The average length of stay is higher due to one patient on a ventilator who was hospitalized for the full year.

For 1997 inpatient admissions totaled 201 with 175 of those admissions having a primary diagnosis of tuberculosis. The average length of stay was 122 days and the hospital had an average daily census of 67 patients.

TCID Patient Admissions - 1997

Inpatient Origin Analysis				
				Cumulative
	Bexar	49	24.4%	24.4%
	Harris	28	13.9%	38.3%
	Travis	20	10.0%	48.3%
	Nueces	9	4.5%	52.7%
	El Paso	8	4.0%	56.7%
	Webb	7	3.5%	60.2%
	Val Verde	5	2.5%	62.7%
	Hildalgo	5	2.5%	65.2%
	Maverick	4	2.0%	67.2%
	All Other	66	32.8%	100.0%
	Total	201	100.0%	

Approximately one-fourth of the inpatient admissions (24.4%) were for patients residing in Bexar County while admissions from Harris and Travis counties combined for an additional 23.9%. Patients from Dallas and Houston are often referred to UTHC-Tyler. Parkland Memorial Hospital in Dallas has the most cases in Texas each year hospitalized with a partial diagnosis of tuberculosis. The remaining TCID admissions were generally for patients residing in south and central Texas. Over 75% of admissions were male and the majority were adults between the ages of 25 and 64 years, which is consistent with overall demographics for TB patients.

TCID Patient Admissions - 1997

Sex			
	Male	155	77.1%
	Female	46	22.9%
		201	100.0%
Age Groups			
	0-14	0	0.0%
	15-24	11	5.5%
	25-44	104	51.7%
	45-64	66	32.8%
	>65	20	10.0%
		201	100.0%
Race			
	White	48	23.9%
	Black	37	18.4%
	Hispanic	109	54.2%
	Asian	5	2.5%
	Other	2	1.0%
		201	100.0%

Most of the patients admitted (54.2%) were of Hispanic origin while approximately 24 percent were white and 18.4 percent were black.

Service Volume - Outpatient

There were 8,798 outpatient visits in 1997 (approximately 7,700 for TB). Approximately 30% were for patients residing in Bexar county. The other visits were primarily for patients residing in the southern region of Texas, most often from counties without hospital districts or other public funding mechanisms.

TCID Outpatient Visits - 1997

Outpatient Origin Analysis				
				Cumulative
	Bexar	2682	29.9%	29.9%
	Zavala	1161	12.9%	42.8%
	Atascosa	908	10.1%	52.9%
	Medina	694	7.7%	60.6%
	Karnes	659	7.3%	68.0%
	Frio	502	5.6%	73.6%
	Wilson	471	5.2%	78.8%
	Guadalupe	251	2.8%	81.6%
	Uvalde	161	1.8%	83.4%
	Other	1489	16.6%	100.0%
	Total	8978	100.0%	

Patient Charges

Total patient charges for 1997 for TCID were approximately $10.0 million. Of that approximately $7 million was for indigent patients without a source of funding and therefore not collectible. The remaining $3 million was for Medicaid, Medicare, private insurance and private pay patients. Due to the reimbursement structure for Medicare and Medicaid (cost based), a significant amount of charges to these programs are not collectible and are written off as contractual adjustments. Collections for 1997 have amounted to approximately $1.4 million. Additional amounts for 1997 may yet be collected, but the collection percentage of charges for 1997 is expected to be approximately 14 percent of charges. Charges and collections for the five-year period ending FY '97 were as follows:

TCID					
	1993	1994	1995	1996	1997
Charges	$ 16,069,465	$ 16,297,201	$ 13,336,177	$ 10,763,383	$ 10,019,931
Collections	2,867,668	2,874,274	2,762,354	2,285,496	1,381,850
% Collected	17.85%	17.64%	20.71%	21.23%	13.79%

Note: Reductions in patient charges since 1994 are primarily the result of a reduction in services offered. Since 1994, the following services were eliminated at TCID: Surgery; Intensive Care; Podiatry; Gynecology; Cancer Clinic; Thoracic Surgery Clinic; Hansen's Disease Inpatients; and Dental Clinic.

Patient Citizenship

The admission or service criteria at the TDH TB hospitals do not involve the patient's citizenship. Having a proper referral, being a "resident" of the state, and presenting themselves for care at the hospital with a condition certified by a physician as needing hospitalization assures admission. The number of non-US citizens seen at TCID in 1997 is estimated to be 22 percent of inpatient admissions. Citizenship data for outpatient visits is not available.

Operating Costs

Total operating expenditures for FY '97 were $14.96 million, of which $9.9 million was funded with state general revenue appropriations and $1.3 million from TDH transfers. Other funding sources included fees and receipts from other payers such as Medicare and Medicaid and federal grants. It is important to note that the TCID generated DISPRO payments of $16.2 million ($10.2 million Federal share) for the year which was transferred to the State's general fund.

Facility and Infrastructure

The facilities used by TCID were constructed four decades ago and were originally designed for patients whose length of stay would be measured in months and years. Shifting modalities of treatment and changes in the mix of patients toward those who are more acutely ill have resulted in an attempt to provide general acute care in a long term care facility. In addition to the costs associated with an inefficient design, there are costs incurred in maintaining and renovating the aging buildings. Though substantially sound in structure, such items as roofs, mechanical and electrical systems, and plumbing must be repaired frequently. In addition, the facility was built at a time when asbestos was in common use. Asbestos abatement must be accomplished in specific areas where TCID staff comes into direct contact with contaminated areas, such as the crawl space under buildings, mechanical rooms, and above ceilings. As noted in the Kennedy report, there is a "domino" effect when initiating a renovation given the complexity of physical plant problems. Potential loss of JCAHO accreditation during the next review scheduled for 1999 poses a major problem.

There have been numerous studies performed during recent years that provide estimated costs for correcting physical plant problems. Those studies are summarized in the Kennedy report (Appendix A) and detail estimated total construction costs for renovations for TCID in San Antonio at $24,949,500.

The results of those studies were relied upon for purposes of this study per the Request for Proposal.

Based on the findings of those studies and on facility inspection, infrastructure and physical plant reconfiguration alternatives have been examined. Those alternatives include: 1) renovation as described in the Kennedy Report; 2) selected renovation and consolidation of services (Appendix C); 3) facility replacement with new construction of a 75 bed medical/support service (Appendix D); and 4) facility replacement with new construction of a 75 subacute facility (Appendix E). Estimated capital costs for each option are:

	Estimated Capital Cost
Renovate all existing facilities (Kennedy report Appendix A)	**$25,000,000**
Consolidate Services/Renovate selected facilities (Appendix C)	**$10,450,000**
New Construction (75 bed medical/support service) (Appendix D)	**$26,000,000**
New Construction (75 bed subacute facility) (Appendix E)	**$21,000,000**

Staffing: Employees and Medical Staff

TCID currently is staffed with approximately 300 full time employees with an approximate annual payroll of $7.2 million. The Women's Health Laboratory is staffed with an additional 34 employees with an annual payroll of approximately $1.3 million. The medical staff is comprised of eleven attending physicians (state employed) and seventeen consulting physicians. Specialties include: Internal Medicine/Pulmonary; Internal Medicine/Gastroenterology; Ophthalmology; Internal Medicine/Nephrology; Psychiatry; Radiology; General Medicine; Internal Medicine/Hematology/Oncology; Neurology/Neuro Oncology; Speech Pathology; Orthopedic Surgery; Pathology; Dentistry; Podiatry; Internal Medicine/Infectious Disease; Internal Medicine/Endocrinology/Geriatrics; Tropical Medicine; and Psychology. According to the hospital management, all but one of the medical staff are Board certified in their respective areas.

South Texas Hospital

History

South Texas Hospital (STH) was inaugurated in the mid-1950s as the Harlingen State Tuberculosis Hospital, with bed capacity of 565 for the control of tuberculosis and the care and treatment of other chest diseases. The land on which the hospital is built is owned by the TDH. In 1983, the Legislature broadened the mission and changed the name of the facility to South Texas Hospital, and due to the changing patterns of care for patients with tuberculosis, allowed the transfer of three buildings to the custody of Mental Health and Mental Retardation. In 1989, the Texas Legislature gave the hospital the authority to establish cancer screening, diagnostic and education services and obstetrical and gynecological services.

STH is located to meet the needs of the residents of Cameron, Willacy, Starr, and Hidalgo Counties. It has administrative offices, diagnostics, surgical spaces, and inpatient beds in one structure which adjoins two large clinic structures with various other support structures. Inpatient, outpatient, reference, and education programs are dedicated to deliver and support needed public health services for the programs sponsored and funded by the Texas Department of Health, including:

- **Care for patients with tuberculosis and complicating illnesses;**
- **Treatment and clinical support for diabetic, surgical, complicating TB, pediatric, and women's health needs;**
- **Health-related education and research; and**
- **Clinical and reference diagnostic services supporting TDH-sponsored programs and Public Health Region 11 services.**

In addition, the STH shares a campus with the TDMHMR and both agencies share selective support services including dietary, laboratory, and laundry facilities.

Service Volume - Inpatient

		1997			
		South Texas Hospital			
Inpatient					Avg. Daily
		Admissions	ALOS	Pt. Days	Census
TB		98	79.36	7,777	21.31
Medical		126	21.00	2,646	7.25
Surgical		348	4.00	1,392	3.81
HIV/Aids Related		1	41.00	41	0.11
	Totals	573	20.69	11,856	32.48

For 1997 inpatient admissions totaled 573 with 98 of those admissions having a primary diagnosis of tuberculosis. The average length of stay for the TB admissions was 79 days. The hospital had an average daily census of 32 patients for both TB and medical and surgical patients.

South Texas Hospital Admissions - 1997

Inpatient Origin Analysis				
				Cumulative
	Cameron	286	49.9%	49.9%
	Hildalgo	234	40.8%	90.8%
	Willacy	18	3.1%	93.9%
	Starr	16	2.8%	96.7%
	Kleberg	5	0.9%	97.6%
	Duval	1	0.2%	97.7%
	Nueces	7	1.2%	99.0%
	Jim Wells	1	0.2%	99.1%
	Jim Hogg	5	0.9%	100.0%
	Total	573	100.0%	

Over 90 percent of the inpatient admissions were for patients residing in either Cameron or Hildalgo county. All admissions were for patients residing in the South Texas area.

South Texas Hospital Admissions - 1997

Sex			
	Male	126	22.0%
	Female	447	78.0%
		573	100.0%
Age Groups			
	0-14	11	1.9%
	15-24	42	7.3%
	25-44	237	41.4%
	45-64	239	41.7%
	>65	44	7.7%
		573	100.0%
Race			
	White	18	3.1%
	Black	2	0.3%
	Hispanic	551	96.2%
	Asian	2	0.3%
	Other	0	0.0%
		573	100.0%

Seventy-eight percent of the admissions were women, with the majority of admissions between the ages of 25 and 64 primarily due to the medicine and surgery services provided at STH Women's Center. Over 96 percent of admissions were of Hispanic origin.

Service Volume - Outpatient

South Texas Hospital Outpatient Visits - 1997

Outpatient Origin Analysis				
				Cumulative
	Cameron	20,724	71.76%	71.76%
	Hildalgo	7,018	24.30%	96.06%
	Willacy	837	2.90%	98.96%
	Starr	289	1.00%	99.96%
	Nueces	6	0.02%	99.98%
	Bexar	6	0.02%	100.00%
	Total	28,880	100.0%	

All but 40 of the 28,880 outpatient visits were medical/surgical related. Outpatient TB visits are primarily seen in the TDH Region 11 outpatient clinic which is also located on the STH campus but administered by TDH Region 11 with assistance from STH physicians, nursing, and support staff.

Patient Citizenship

The admission or service criteria at the TDH hospitals do not involve the patients' citizenship. It is based on patients having a proper referral, being "residents" of the state, and presenting themselves for care requiring hospitalization. The number of non-US citizens seen at STH in 1997 for TB services is estimated to be 57.2 percent of inpatient admissions and 33 percent of the outpatient visits. Until regulations anticipated from Immigration Reform Legislation are implemented, citizenship data will not be available for STH patients for medicine and surgery.

Non-citizens (whether in Texas legally or illegally) have to be treated when they are contagious. Referral to Mexico for treatment is generally not feasible for the types of patients admitted at STH, because the expertise and resources to treat drug resistant TB are not available in Mexico. If these patients are not treated, Texas risks allowing them to continue transmitting TB, or, worse, of developing more resistant TB. Whether this happens in Texas or just across the border, Texas will be affected by these TB treatment failures.

Patient Charges

Total patient charges for 1997 for STH were approximately $17.5 million. Of that approximately $9 million was for indigent patients without a source of funding and therefore not collectible. The remaining $8.5 million was for Medicaid, Medicare, private insurance and private pay patients. Due to the reimbursement structure for Medicare and Medicaid (cost based) a significant amount of charges to these programs are not collectible and are written

off as contractual adjustments. Collections for 1997 have amounted to approximately $2.4 million. Additional amounts for 1997 may yet be collected, but the collection percentage of charges for 1997 is not expected to be materially different from prior years. Charges and collections for the five-year period ending FY '97 were as follows:

South Texas Hospital					
	1993	1994	1995	1996	1997
Charges	$ 12,498,445	$ 13,209,487	$ 14,321,277	$ 14,520,090	$ 17,573,315
Collections	2,564,407	2,954,459	2,485,941	1,955,842	2,293,868
% Collected	20.52%	22.37%	17.36%	13.47%	13.05%

Note: A significant portion of the increase in charges for 1997 was due to an increase in the rate structure for the hospital and an increase in lab services provided to outside providers. Due to the high level of uninsured patients and the contractual agreements with Medicare, Medicaid and other insurers, the price increase and the increase in lab services had little impact on actual collections. Collections as a percentage of charges has decreased over the 5-year period primarily due to more indigent patients and changes in reimbursement policies from various third-party payers.

Operating Costs

Total operating expenditures for FY '97 were $14.5 million, of which $6.9 million was funded with state general revenue appropriations and $2.9 from TDH transfers. Other expenditures were primarily funded from reappropriated receipts from other payers such as Medicare and Medicaid. It is important to note that the STH generated $8.8 million in Medicaid DISPRO reimbursement ($5.5 million Federal share) for the year which was transferred to the general fund.

Facility and Infrastructure

TDH has conducted studies of the South Texas Hospital relative to physical plant conditions that describes the need for repairs and/or replacement construction. Those findings are contained in the Kennedy report (Appendix A). These previous studies and their findings have been relied upon for this report per the instructions in the Request for Proposal. The Kennedy report detailed total renovation costs for STH in Harlingen at $18,560,426.

Based on the findings of those studies and on facility inspection, infrastructure and physical plant reconfiguration alternatives that have been examined. Those alternatives include: 1) renovation as described in the Kennedy Report; 2) Facility replacement with new construction of a 75 bed medical/surgical facility (Appendix D); and 3) Facility replacement with new construction of a 75 subacute facility (Appendix E). Estimated capital costs for each option are:

	Estimated Capital Cost
Renovate all existing facilities (Kennedy report Appendix A)	**$18,500,000**
New Construction (75 bed medical/surgical facility) (Appendix D)	**$26,000,000**
New Construction (75 bed subacute facility) (Appendix E)	**$21,000,000**

NOTE: Renovations as described in the Kennedy report can be accomplished over a phased-in approach. That would not require the full $18.5 million to be funded in one year. A phased-in schedule would require:

FY 2000-2001: $ 8,168,816
FY 2002-2003: $10,391,610
Total: $18,561,426

Staffing: Employees and Medical Staff

The STH currently is staffed with approximately 286 full time employees with an approximate annual payroll of $6.2 million. The medical staff is comprised of eight active physicians (state employed), twenty-one contractual physicians, and twenty-two consulting physicians. Also, included on the staff are forty residents from UTMB Galveston, UTHSC-San Antonio, the Valley Baptist Medical Center Family Practice Residency Program, the McAllen Family Practice Residency Program, and the UTMB-UTPA Physician Assistant (PA) Program in Edinburg. Specialties include General Surgery, Internal Medicine/MDRTB, Internal Medicine/Infectious Disease, Internal Medicine/Endocrinology, Pediatrics, OB/GYN, Pathology, Radiology, Family Practice, Podiatry, Anesthesiology, Allergy, and Oncology. The medical staff, except for one, are also all Board Certified in their respective specialties.

University of Texas Health Center - Tyler

History

The University of Texas Health Center at Tyler (UTHC-Tyler) was created under the original charter by the 50th Texas Legislature (SB 296) as the East Texas Tuberculosis Sanitorium. The facility was made available to the State of Texas from the federal government via a transfer of the Camp Fannin Hospital Complex. The 62th Legislature changed the institution's name to the East Texas Chest Hospital (HB 403) and designated it as a primary referral facility in Texas for patient care, education, and research in diseases of the chest (HB 799). The institution continued its major commitment in the area of tuberculosis care and treatment as a Texas Department of Health facility. In 1977, the 65th Legislature, through SB 1300, authorized transfer of the institution to the University of Texas System Board of Regents. The institution was to continue its responsibilities as designated under the charter of the East Texas Chest Hospital, including its continued support of patient care needs in the area of tuberculosis. The facility was designated as a teaching hospital and renamed the University of Texas Health Center at Tyler.

Building on this heritage of expertise in the treatment and management of tuberculosis, the 73rd Legislature appropriated funds for a special project of the institution - the Center for Pulmonary and Infectious Disease Control (CPIDC). The arguments for the establishment of the Center and its statewide services included the existing expertise at UTHC-Tyler in pulmonary medicine and infectious disease, with particular experience in drug trials and consultative support in these areas through the State.

Services

CPIDC's program includes availability of consultative support to Texas physicians and health care facilities regarding all pulmonary infectious diseases, but with a particular emphasis in control of tuberculosis. An average of 120 telephone calls are received monthly by the Center.

Educational programs are directed to health care workers, including physicians, practicing nurses, LVNs, and nursing students. The major expertise within the Center includes tuberculosis, multidrug-resistant TB, non-TB mycobacteria, as well as other infectious diseases. The educational programs of the Center have reached over 1,500 attendees per year. These programs are coordinated with TDH regional offices, the TDH TB Elimination Division, TB Education Center, and TDH hospitals.

CPIDC has taken a major role in further developing inpatient services at UTHC-Tyler, as well as outpatient TB clinics in support of TDH Region 4/5 in Tyler. Weekly TB conferences are held in conjunction with the program and telemedicine support from the program has existed for several years with the TDH facilities located in Harlingen and San Antonio.

Literature supporting CPIDC programs has been developed to address areas of interest not only in tuberculosis, but also other infectious diseases. Many items are published in Spanish as well as English.

The Department of Microbiology, which interacts closely with CPIDC, is nationally and internationally known for its studies in the treatment of non-TB mycobacteria. The resources of this basic science/clinical research laboratory add further dimensions to the CPIDC program.

UTHC-Tyler's expertise in tuberculosis research is also supported by the presence of six nationally funded grants with emphasis including research targeting the development of vaccine for tuberculosis, as well as basic science endeavors focusing on the molecular biology of the bacterium.

UTHC-Tyler was honored by TDH in 1996 for its achievements through CPIDC by being awarded the "Golden Peach Award." This was in recognition of the "excellent work consistently demonstrating the practice of TB control."

Other active collaborations between UTHC-Tyler and the TDH hospitals include the availability of clinical support, surgical expertise, and telemedicine consultation. As an academic center, UTHC-Tyler has enabled the TDH hospitals to participate in an important clinical trial. To expedite the trial process, a principal investigator's role was assumed by a faculty member at UTHC-Tyler. This allowed certain credentialling aspects required by the federal agency to be assumed by the academic center and enabled the TDH hospital medical staff to achieve its desired participation in the trial. These examples typify the types of collaborations that exist and can be expanded in the future between UTHC-Tyler and TDH in addressing common problems associated with controlling tuberculosis in the most cost-efficient manner for the citizens of Texas.

CRITERIA USED TO DEVELOP OPTIONS

To examine the complex benefit and impact considerations involved with this study, four categories of criteria were developed which were approved by an executive oversight committee comprised of TDH management and clinical experts. Those four categories of criteria in order of priority were:

1. **Public Health Policy**
2. **Clinical Factors**
3. **Cost and Economic Factors/Benefits**
4. **State and Local Community Expectations**

Within each category, there were numerous sub-criteria which included the following:

1. **Public Health Policy**
    a) **Compliance with existing state statutes regarding public health mission for TDH.**
    b) **Compliance with federal TB guidelines.**
    c) **Accommodation of projected demographic changes affecting demand for TB services and other clinical services and support for next twenty years.**
    d) **Promotion of access to needed health care (in addition to TB) for persons in the area.**
    e) **Integration of existing private and public TB health services in the community.**
    f) **Accommodation for the projected incidence of TB requiring inpatient treatment specifically related to Multidrug resistant TB.**
    g) **Promotion of public health education in the area.**
    h) **Conform with the TDH long term strategic plan.**
    i) **Promotion of effective tracking and reporting of TB and related infectious diseases.**
    j) **Accommodation for bi-national TB agreements.**
    k) **Incorporation of other states' "best practices" when appropriate.**
    l) **Provision of quarantine facilities for court ordered individuals.**
    m) **Supply and demand of qualified clinical and patient care staff.**

2. **Clinical Factors**
    a) **Incorporation of developments in methods of treating TB including Directly Observed Therapy (DOT), and Multidrug Resistant TB.**
    b) **Promotion of research in clinical treatment strategies.**
    c) **Assurance of quality and accreditation of physical facilities in which patients are treated.**
    d) **Promotion of TB patient care and outreach programs related to TB detentions and treatment.**
    e) **Provision of the availability of cancer screening, diagnostic services,**

educational services, gynecological services, diabetic services, and other inpatient and outpatient services for persons who choose access to these services. (Applicable to the South Texas Hospital)

f) **Provision for the coordination and quality of other public health services in the area.**
g) **Provision for coordination of services provided by other state agencies.**
h) **Provision for clinical training capacity for both specialty consultation and clinical expertise, laboratory support, and other diagnostic and intervention radiology services.**
i) **Accommodation of TB treatment changes that develop during the next twenty years such as moving to more outpatient services versus inpatient or new treatment methods.**
j) **Incorporates other states' "best practices" when appropriate.**

3. **Cost and Economic Factors/Benefits**

a) **Provision of inpatient and outpatient services at costs comparable to the current costs being incurred at the TDH hospital.**
b) **Creation of budget predictability.**
c) **Promotion of economy of scale through sharing facilities between state agencies.**
d) **Promotion of economy of scale for other public health services offered in the area by the TDH.**
e) **Impact analysis for creating Medicaid eligibility class for TB infected persons.**
f) **Evaluation of the opportunity to deliver required services by providers other than TDH.**
g) **Promotion of stable economic public employment in the area.**
h) **Provision of a safety net to other public hospitals throughout the state, allowing transfer of indigent patients needing long term TB inpatient and/or outpatient management.**
i) **Accommodation of immigration issues between the US and Mexico.**
j) **Coordination between the federal and state government.**
k) **Promotion of economic and efficient lab services for the state.**
l) **Incorporation of other states' "best practices" when appropriate.**

4. **State and Local Community Expectations**

a) **Consumer and advocacy groups.**
b) **Business groups.**
c) **Local governments such as counties, cities, and school leaders.**
d) **Higher education medical schools.**
e) **Local medical societies.**
f) **Federal agencies with operational responsibilities in the area including military groups.**
g) **Private hospitals.**
h) **Local public health officials.**

i) **National health planning and disease management organizations.**
j) **State medical organizations including appropriate medically trained professionals and hospital groups/associations.**
k) **Local state elected officials.**
l) **Local community groups.**
m) **TDH hospital employees**
n) **Incorporation of other states' "best practices" when appropriate.**

In addition to reviewing relative clinical trends and treatment strategies, demographic data, legislative directives, regulatory guidelines, previous studies, financial and utilization data, admission criteria, patient origin data, and cost data, surveys and interviews were conducted to assemble additional information to aid in the overall analysis.

Surveys

Written surveys, designed to reach out to a wide array of stakeholders, focused only on TB. The intent was to contact individuals identified as having experience in the treatment of TB in Texas and other interested parties who would be in positions to provide expert input for the long range plan for the two TDH hospitals.

The Long Range Plan Survey was conducted during January, 1998. With the assistance of the Long Range Plan Steering Committee, the survey instrument was developed and sent to 103 participants. Tonn and Associates received 50 surveys by the middle of February. The responses were divided into the following participatory categories: physicians, healthcare administrators, local health officials, and TDMHMR administrators.

The survey consisted of fourteen basic questions redeveloped in several formats. The formats included yes/no questions, multiple choice options, most appropriate ranking of the treatment and service of TB, and discussion questions. The last question requested additional comments.

In general, the respondents expressed strong support for the two TDH hospitals continuing to provide the current array or services in their current locations. A copy of the survey instrument, a list of the stakeholders who were surveyed, and a summary of the input received are included in Appendix F.

Interviews

In addition to the surveys and at the direction and close involvement of TDH management, interviews were conducted with a number of stakeholders. It was not feasible within the scope of this study to interview all identified stakeholders; consequently, TDH identified a subset for personal interviews. A list or those interviewed is included as Appendix G.

These interviews overlapped to some extent with the written surveys in order to assure that stakeholders were informed of the purpose and scope of the study and to seek their input. In general, their responses regarding the need for the TDH inpatient TB services, the quality of these services and the economic impact of closure of either facility mirrors the written survey

responses.

The interview process also helped in the examination of potential options. This is best illustrated by the lack of positive responses to the privatization and/or outsourcing alternative. Responses regarding outsourcing range from the difficulties accommodating TB patients in general acute hospitals including the special need for positive air control and other infection prevention control measures which considered are costly and difficult to justify. Additionally, the general population does not have a positive attitude toward the prospect of sharing a medical facility with infectious TB and chronic Hansen's disease patients.

Private hospital representatives also believe providing inpatient TB services to the TDH hospitals' patients is not a good financial investment for them, given the two TDH hospitals' high uncompensated care rate.

Interviews did reveal interest from the University of Texas Health Medical Branch-Galveston for their increased involvement in the clinical care other than TB services provided at STH. Conversely, neither UTMB or UTHSC-San Antonio expressed interest in the STH or TCID TB care. UTHSC-San Antonio indicated they were not in a position to consider taking over the research laboratory functions at TCID.

Various legislative officials expressed their deep interest about the patients being served, and stated they believed that the two facilities were meeting vital healthcare needs in a quality manner. They also expressed deep concern about the economic impact that would be felt by hospital employees and the community(ies) if either hospital were to close.

Meetings with TDH Hospital Staff
Meetings were also conducted with staff of both TDH hospitals to review the purpose and scope of the study and to invite their input. The major points of discussion included:

- **Current and future capacity and need**
- **Cost benefit analysis**
- **Facility and service options**
- **Architectural and engineering issues**
- **Clinical and Medical staff**

Common comments from the hospital staff members included concern about the future of the facility, concern about the ability to compete effectively with other local hospital providers, and appreciation for the information regarding the purpose of the study. Continued response from hospital staff was actively solicited by ongoing e-mail address; anonymous input methods; and regular steering committee newsletters. More than fifty questions from hospital staff have been researched and responded to by the steering committee up to this time.
(See Appendix I.)